Virginia Department of Health
TB Intake Sheet

WebVision # **ICD9#**

Last Name_____ _____First Name_____ Middle_____
Birth Date___/ /____ Race___ Sex____ Marital status_____Parent/Guardian _____
Home Address_____ Apt # _____
City_____ _____ State_____ Zip_____
Home Phone _____ Work Phone:_____Cell Phone _____
Country of Origin _____ Year of arrival _____ Preferred Language _____
Provider _____ Provider Phone _____
Reporting Source Reporter Phone

TB Symptoms (Check all that apply. May skip section and complete Health History form if from patient interview)
_____None
_____Cough ≥ 3 weeks
_____Productive? Y N Hemoptysis? Y N
_____Fever, unexplained
_____Unexplained weight loss
_____Poor appetite
_____Night Sweats
_____Fatigue

Site: __ Pulmonary __ Extrapulmonary(specify)_____
Weight _____ Height _____
Initial blood work? ☐ Yes ☐ No Report: ☐ Yes ☐No
LMP EDD BCG ☐ Yes ☐ No

TST/IGRA Result
Date Given _____ Date Read _____
Induration_____mm ☐ Positive ☐ Negative
___ Borderline/Indeterminate (IGRA only)

HIV Testing
___ Not Tested
___ Tested
___ Negative
___ Positive
___ Results pending
Date _____

Current Chest x-ray **Date _____**
Location of film: _____ Addl. Old Films: Y N
☐ Negative ☐ Abnormal ☐ Cavitary
Describe:

Other Info
Hospitalized: Y N
Where?
Room # _____

Additional Individual Risk for Infection (Check all that apply)
_____ Identified Contact (Case_____)
_____ ≥ 3 months in high prevalence country
_____ Resident/employee congregate setting
_____ Medically underserved
_____Uses illegal drugs

Individual Risk for Progression to Disease
_____HIV infection
_____ Medical conditions that increase risk (diabetes, ESRD, Cancer, 10% below ideal weight, etc.)
_____ History of inadequate TB treatment
_____ Immunosuppressive therapy (steroids, cancer treatment, include treatment for Rheumatoid Arthritis such as Remicade, Humira, etc.)

Initial Bacteriology (Check for susceptibility if lab not DCLS)

Date	Smear	Culture	Sensitivity

Current Treatment Regimen ☐ **DOT** ☐ **Self**

Drug	Dosage	Frequency	Start Date	Stop Date

Additional Comments (additional treatment information, work site, school, living arrangements, other activities)
Class B Immigrant/Refugee? ☐ Yes A # _____

Date _____ Completed by _____

Clinician Orders

☐ Isoniazid _____ mg P.O. Daily(7) Daily (5) Twice Weekly Thrice Weekly Weekly
☐ Rifampin _____ mg P.O. Daily(7) Daily (5) Twice Weekly Thrice Weekly
☐ Pyrazinamide _____ mg P.O. Daily(7) Daily (5) Twice Weekly Thrice Weekly
☐ Ethambutol _____ mg P.O. Daily(7) Daily (5) Twice Weekly Thrice Weekly
☐ Pyridoxine _____ mg P.O. Daily(7) Daily (5) Twice Weekly Thrice Weekly
☐ Rifapentine _____mg P.O. Daily(7) Daily (5) Twice Weekly Thrice Weekly Weekly
☐ Meds by DOT
☐ Sputum collection protocol
☐ Blood work Specify: _____

Clinician Assessment/Progress Notes

Date _____ Clinician Signature _____

TB Intake: 6/2014